Department of HUMAN SERVICES

Integrated Health Home Learning Activities and Topics 2022

The Health Home Learning Collaborative is tasked with the development of learning topics and activities. Every Health Home webinar is held the 3rd Monday of every month from 2pm – 3pm with two face-to-face Learning Collaboratives (spring/fall).

Date	Topic
January 24*	**Evidence-based Guidelines/Live Demo of MCO Member Websites** Objectives: Health Homes coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines. Health Homes monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventative services. Additionally, Health Homes complete continuous claims-based monitoring of care to ensure evidence-based guidelines are being addressed with members/ families. In terms of health education, Health Homes provide information to members and families about preventing and managing chronic conditions using evidence-based sources. The Lead Entities (MCOs) provide member websites that contain evidence-based health information about medical and behavioral conditions, medications, and treatment options as well as resources and links for national and local support programs and resources. In this webinar, Health Homes will review where to find evidence-based clinical guidelines and evidence-based sources. This webinar will also include a live MCO member website demo. ***(Reference: Comprehensive Care Management, Care Coordination, Health Promotion, Individual and Family Support, Referral to Community and Social Support Services)***
https://attendee.gotowebinar.com/register/4173739334628623349	
February 21	**Transitional Care** Objectives: Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of care. This webinar will cover how Health Homes can build effective processes around transitions from inpatient/NF/PMIC to community, successful reengagement back to the home community, and parent engagement while a child is in PMIC. ***(Reference: Comprehensive Transitional Care)***
https://attendee.gotowebinar.com/register/4639128048704177678	
March 21	**Care Coordination: Understanding Long-term Care Services, Medicaid Programs, Mental Health & Disability Service Regions, & Court-ordered Services** Objectives: Health Homes arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care.

	This webinar will focus on the process of making referrals for long-term care including waivers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID), and nursing facilities. Health Homes will also review the specific types of Medicaid, understand the role of Mental Health and Disability Service (MHDS) regions, and understand the role of court orders and mental health advocates. ***(Reference: Care Coordination)***
https://attendee.gotowebinar.com/register/3236315038894677005	
April 26	**Face-to-Face:** **Services and Supports** Objectives: Health Homes provide resource referrals or coordinate access to recovery or social health services available in the community which includes understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs. During this presentation, Health Homes will review how to assist members in accessing other Medicaid services (e.g., Home health, durable medical equipment (DME), vision, hearing, dental, transportation), housing options, community resources, and for members transitioning out of Medicaid, identifying supports and resources. ***(Reference: Care Coordination and Referral to Community and Social Support Services)*** **Team-based Care** Objectives: The Health Home program has teams of health care professionals to deliver personalized, coordinated care for individuals through providing the six core Health Home services. Well implemented team-based care has the potential to improve the comprehensiveness, coordination, efficiency, effectiveness, value of care, and satisfaction of members and staff. During this presentation, Health Homes will review the components of team-based care and share their own successes with team-based care and opportunities for further success. ***(Reference: Teams of Healthcare Professionals / Provider Standard)***
Face-to-Face agenda link provided closer to meeting date	
May 16	**Annual interRAI Training** Objective: Annual training on the interRAI assessment tool for the Children's Mental Health Waiver. ***(Reference: Iowa Administrative Code)***
https://attendee.gotowebinar.com/register/1392490114207363085	
June 20	**Comprehensive Assessment Process - engaging members, completing the comprehensive assessment & social history** • **Pediatric / Family** • **Adult** Objectives: For each enrolled member, Health Homes complete a comprehensive assessment at least every 12 months or more frequently as needed that includes a review of physical and behavioral health components, medication reconciliation, functional limitations, and appropriate screenings. Assessment

	also includes current and historical information and assesses the member's readiness for self-management. In this webinar, Health Homes will review the components of the Comprehensive Assessment and Social History and its integration with the plan of care. ***(Reference: Comprehensive Care Management)***
https://attendee.gotowebinar.com/register/5519776389413399309	
July 18	**Risk Stratification** Objectives: Health Homes monitor member gaps in care and predicted risks based on medical and behavioral claims data. Through coordinated and integrated care, Health Homes conduct interventions as indicated based on the member's level of risk. During this presentation, Health Homes will review the background and purpose of risk stratification including the role of electronic health records in identifying level or category of risk. Health Homes are encouraged to share how they use risk stratification in their practice. ***(Reference: Comprehensive Care Management)***
https://attendee.gotowebinar.com/register/6513545784922934028	
August 15	**Person-Centered Planning - philosophy & CMS requirements, completing the PCSP** Objectives: Health Homes provide care coordination and case management services to Habilitation and Children's Mental Health waiver populations. A person-centered service plan (PCSP) is created through a person-centered planning process, directed by the member or member's guardian, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes. During this webinar, Health Homes will review the components of the person-centered process and person-centered service plan. ***(Reference: Iowa Administrative Code)*** ***42 CFR 438.208(c)(3)(i)***
https://attendee.gotowebinar.com/register/7063205941299328526	
September 27	**Face-to-Face:** **Motivational Interviewing / Client Follow Through** Objectives: Health Homes use Motivational Interviewing and other evidenced based practices to engage and help members in participating and managing their own care. During this webinar, Health Homes will review the components of Motivational Interviewing, Whole Health Action Management (WHAM) and Wellness Recovery Action Plan (WRAP) and share how they have successfully implemented these programs. ***(Reference: Health Promotion, Individual and Family Support)*** **Person-Centered Thinking** Objectives: Person centered thinking is a hands-on learning and skill development training. The curriculum includes exploring skills that are geared toward building our internal capacity to help individuals take positive control in their lives, and support efforts to improve person-centered practices.

	The following person-centered tools will be reviewed: • MAPS (Making Action Plans) • PATH (Planning Alternative Tomorrow with Hope) • PFP (Personal Future's Planning) • WRAP (Wellness Recovery Action Plan) • 4+1 Questions • Relationship Maps • Routines and Rituals • Good Day / Bad Day • Learning Log **Treatment Plan Goals** • **Pediatric** • **Adult** Objectives: Health Home create a person-centered care plan with the member and individuals chosen by the member that addresses the needs of the whole person. Health Homes monitor and intervene on progress of treatment goals using holistic clinical expertise. In this webinar, Health Homes will focus on how to write individualized, meaningful goals with the member. Examples will include goals for both adult and pediatric populations. ***(Reference: Comprehensive Care Management)***
Face-to-Face agenda link provided closer to meeting date	
October 17	**Transitional Youth** Objectives: For pediatric members, Health Homes facilitate transfer from pediatric to an adult system of health care. In this webinar, Health Homes will review best practice in assisting transitional youth and their caregivers / supports in accessing resources and services. ***(Reference: Comprehensive Transitional Care, Individual and Family Support)***
https://attendee.gotowebinar.com/register/5963777876407102219	
November 21	**Quality Improvement** Objectives: Health Homes utilize continuous quality improvement plans to address gaps and opportunities for improvement. Through their continuous quality improvement program, Health Homes collect and report on data that allows for evaluation of individual outcomes, experience of care outcomes, and quality of care outcomes at the population level. During this webinar, Health Homes will review quality improvement methods and share their successes with quality improvement and opportunities to enhance their success. ***(Reference: Provider Standards)***
https://attendee.gotowebinar.com/register/8985689928195959311	
December 19	**Member Rights & Responsibilities** Objectives: As a consumer of IA-Health Link or Medicaid fee-for-Service, members have rights and responsibilities. Health Homes educate members and provide advocacy on member rights and responsibilities including the right to file a

	grievance and, for members receiving home-and community-based services, independent advocacy services through the Managed Care Ombudsman Program. ***(Reference: Medicaid Member Handbooks, Individual and Family Support)***
https://attendee.gotowebinar.com/register/5708635584723663 48	

*Date adjusted to the 4th Monday of the month to accommodate the observed holiday.

Topics are Subject to Change